CHAPTER 4: PROCEDURES FOR COMPLETING THE RESIDENT ASSESSMENT PROTOCOLS (RAPs) AND LINKING THE ASSESSMENT TO THE CARE PLAN

This chapter provides instructions on how to use the Resident Assessment Protocols (RAPs) to assess conditions identified by the Minimum Data Set (MDS) triggering mechanism. The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental and psychosocial needs of residents.

4.1 What are the Resident Assessment Protocols (RAPs)?

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing facility resident's care plan. The RAPs were created by clinical experts in each of the RAP areas.

RAPs are not required for Medicare assessments. RAPs are ONLY required for comprehensive clinical assessments (Admission assessment, Annual assessment, Significant Change in Status Assessment (SCSA), or Significant Correction of Prior Full assessment (SCPA). However, when a Medicare assessment is combined with a comprehensive clinical assessment, the RAPs must be completed in order to meet the requirements of the comprehensive clinical assessment. RAPs may also be used any time the facility wishes to provide indepth focused review of any area for which RAPs have been developed.

The care delivery system in a facility is complex yet critical to successful resident care outcomes. It is guided by both professional standards of practice and regulatory requirements. The basis of care

delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.

The RAI (MDS and RAPs) is an integral part of this process. It ensures that facility staff collects minimum, standardized assessment data for each resident at regular intervals. The main intent is to drive the development of an individualized plan of care based on the identified needs, strengths and preferences of the resident.

It is helpful to think of the RAI as a process. The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. A risk factor increases the chance of having a negative outcome, or complication. For example, compromised bed mobility increases the risk of a pressure ulcer. In this example, compromised bed mobility is the specific risk factor, and the pressure ulcer is the complication. RAP guidelines may contain cues regarding risk factors and complications associated with the RAP condition. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

RAPs function as decision facilitators, which means they lead to a more thorough understanding of possible problem situations by providing educational insight and structure to the assessment process. The RAPs will give the interdisciplinary team a sound basis for the development of the resident's care plan. After the comprehensive assessment process is completed, the interdisciplinary team will be able to decide if:

- The resident has a troubling condition that warrants intervention, and if addressing this problem is a necessary condition for other functional problems to be successfully addressed;

- Improvement of the resident's functioning in one or more areas is possible;

- Improvement is not likely, but the present level of functioning should be preserved as long as possible, with rates of decline minimized over time;

- The resident is at risk of decline and efforts should emphasize slowing or minimizing decline, and avoiding functional complications (e.g., contractures, pain); or

- The central issues of care revolve around symptom relief and other palliative measures during the last months of life.

OBRA 1987 mandated that facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

4.2 How are the RAPs Organized?

As shown in Appendix C, there are four parts to each RAP:

Section I - The Problem gives general information about how a condition affects the nursing facility population. The Problem statement often describes the focus or objectives of the protocol. It is important when reviewing a "triggered" RAP not to overlook information in the Problem section. Although **Section III - The Guidelines** contain the "detail," the Problem section should be reviewed for information relevant to the assessment.

Section II - The Triggers identify one or a combination of MDS item responses specific to a resident that alert the assessor to the resident's possible problems, needs, or strengths. The specific MDS response indicates that clinical factors are present that may or may not represent a condition that should be addressed in the care plan. Triggers merely "flag" conditions necessary for the interdisciplinary team members to consider in making care planning decisions.

When the resident's status on a particular MDS item(s) matches one of the "triggers" for a RAP, the RAP is "triggered" and a review (with the possibility of additional data gathering and assessment) is required using the RAP Guidelines.

Section III - The Guidelines present comprehensive information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. The Guidelines help facility staff decide if a triggered condition actually does limit the resident's functional status or if the resident is at particular risk of developing the condition.

If the condition is found to be a problem for the resident, the Guidelines will assist the interdisciplinary team in determining if the problem can be eliminated or reversed, or if special care must be taken to maintain a resident at his or her current level of functioning.

In addition to identifying causes or risk factors that contribute to the resident's problem, the Guidelines may assist the interdisciplinary team to:

- Find associated causes and effects. Sometimes a problem condition (e.g., falls) is associated with just one specific cause (e.g., new drug that caused dizziness). More often, a problem (e.g., falls) stems from a combination of multiple factors (e.g., new drug, resident forgot walker, bed too high, etc.).

- Determine if multiple triggered conditions are related.

- Suggest a need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests, consulting psychiatrist, etc.

- Determine if a resident is a good candidate for rehabilitative interventions.

- Identify the need for a referral to an expert in an area of resident need.

- Begin to formulate care plan goals and approaches.

Section IV - The RAP Key has two parts. The first part is a review of the items on the MDS that triggered a review of the RAP. The second part is a summary, but sometimes also provides a clarification of the information in the Guidelines section of the RAP. The RAP Key should be used as a reference, but does not take the place of the main body of the RAP.

There are 18 RAPs in the Resident Assessment Instrument, Version 2.0:

Delirium
Cognitive Loss/Dementia
Visual Function
Communication
ADL Function /Rehabilitation
Urinary Incontinence and Indwelling Catheter
Psychosocial Well-Being
Mood State
Behavior Symptoms
Activities
Falls
Nutritional Status
Feeding Tubes
Dehydration/Fluid Maintenance
Dental Care
Pressure Ulcers
Psychotropic Drug Use
Physical Restraints

4.3 What does the RAP Process Involve?

There are various models for completing the RAP in-depth assessment process for a resident with a particular problem. Assessment of the resident in "triggered" RAP areas may be performed solely by the RN Coordinator (i.e., as the RAI must be completed or coordinated by an RN per the OBRA statute). Generally, the RAPs will be completed by various members of clinical disciplines as appropriate to the needs of individual residents. Facilities may also establish procedures in which certain RAPs are always reviewed by a particular discipline (e.g., the dietitian completes the Nutritional Status and Feeding Tube RAPs, if triggered). The interdisciplinary team may also review RAP Guidelines in a joint manner and have the assessment process flow seamlessly into care planning. There are no mandates regarding the "process" of how facility staff uses the RAPs.

Rather, facility staff should be creative and experiment until they find "what works" most efficiently and effectively for them in achieving the desired outcome (i.e., a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident).

The RAP process includes the following steps:

1. Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary form.

2. Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information, including items not automatically triggered, as needed, to determine the nature of the problem and understand the causes specific to the resident.

3. Staff documents key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:

   - Nature of the condition (may include presence or lack of objective data and subjective complaints).

   - Complications and risk factors that affect the staff's decision to proceed to care planning.

   - Factors that must be considered in developing individualized care plan interventions. Include appropriate documentation to justify the decision to care plan or not to care plan for the individual resident.

   - Need for referrals or further evaluation by appropriate health professionals.

     Documentation about the resident's condition should support clinical decision-making regarding whether or not to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

     The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

4. Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention.

5. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

4.4 Identifying Need for Further Resident Assessment by Triggering RAP Conditions (RAP Process - Step 1)

A RAP may have several MDS items or sets of items that are defined as triggers. Only one of the trigger definitions must be present for a RAP to be triggered, although for many RAPs, each of the specific trigger items that are present must be investigated (e.g., address each of the potential side effects for the Psychotropic Drug Use RAP).

The **trigger definitions** can be found in:

- Section II of each RAP;
- The RAP Key found at the end of each RAP; and
- The RAP Trigger Legend.

The **Trigger Legend** is a **2-page form** that summarizes all of the MDS items that trigger the 18 RAPs. **It is not a required form that must be maintained in the resident's clinical record.** Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.

Most facilities use automated systems instead of the trigger legend form to trigger RAPs. The resulting set of triggered RAPs that is generated by your software program should be matched against the trigger definitions to make sure that triggered RAPs have been correctly identified.[1] CMS has also developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but it is the facility's responsibility to ensure that the software is triggering correctly. At a minimum, ask whether or not the triggered RAPs are what you would have expected. Did the software miss some RAPs you thought should have been triggered? Do some of the RAPs seem to be missing and are there other RAPs triggered that you did not expect?

To identify the triggered RAPs manually using the Trigger Legend:

1. Compare the completed MDS with the Trigger Legend to determine which RAPs are "triggered" for review. Begin by looking at the **KEY** in the upper left corner of the trigger legend form. Note that there are four possible ways for a RAP to trigger:

   The **first**, indicated by a **solid black circle**, is the predominant method and requires only one MDS item to trigger a RAP.

   The **second**, indicated by a "**2" within a solid circle**, requires two MDS items to trigger a RAP.

   The **third**, indicated by an asterisk (*****), requires one of three types of **psychotropic medications** (antipsychotic, antianxiety or antidepressant), and one other item in the Psychotropic Drug Use column indicated by a **solid black circle**.

[1] This process should be performed on a sample of assessment records any time changes have been made in the MDS software.

The **fourth** is indicated by a **small case "a" within a circle**. This is a special ADL trigger that will focus the RAP review on rehabilitation or on the maintenance of current function.

Find the ADL-Rehabilitation Trigger A and the ADL-Maintenance Trigger B columns by scanning the top of the trigger legend form. Notice each ADL column title is marked with a circled "a".

If there are solid circles in both ADL columns, the ADL Maintenance column will take precedence.

2. Look at the two left columns of the Trigger Legend. These columns list the letter and number codes as well as the name of the MDS items to be considered. The third column lists the specific resident codes that will trigger a RAP. The remaining columns list the individual RAP titles.

   To identify a triggered RAP, match the resident's MDS item responses with the "Code" column. If there is a "match," follow horizontally to the right until a trigger is indicated by one of the key symbols. If, for example, there is a solid circle in the column, the RAP titled at the top of that column is "triggered." This means that further assessment using the RAP Guideline is required for that particular condition.

3. Note which RAPs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.

4. Continue down the left column of the Trigger Legend matching recorded MDS item responses with trigger definitions until all triggered RAPs have been identified.

5. When the Trigger Legend review is completed, document on the RAP Summary form which RAPs triggered by checking the boxes in the column titled "Check if Triggered."

EXAMPLES

When Mrs. D returns to her room after eating breakfast, she cannot recall eating breakfast, and always asks the nurse when breakfast will be served. MDS item Short-Term Memory, B2a, has been coded 1 (Memory Problem), and the Cognitive Loss/Dementia RAP is triggered for further assessment.

Mr. F is independent in cognitive skills for daily decision-making. His transferring ability varies throughout each day. He receives no assistance at some times and heavy weight-bearing assistance of one person at other times. The MDS item Decision-making, B4, is coded 0 (Independent). The MDS item Transferring, G1bA, is coded 3 (Extensive Assistance). The ADL-Rehabilitation RAP is triggered for further assessment, focusing on a possible rehabilitative intervention. Rationale for trigger: Mr. F. has good cognitive skills for learning new ways to function and realize his potential.

EXAMPLES
(continued)

Mr. P is receiving an antipsychotic medication two times per day. He has fallen within the last 30 days. The MDS item Antipsychotics, O4a, is coded 7 (Received 7 days a week). The MDS item Falls (in past 30 days), J4a, is checked. The Psychotropic Drug Use RAP is triggered for further assessment. (Note: Because J4a is checked, the Falls RAP will also be triggered.)

Mrs. T is highly involved in activities of the facility. When structured activities are not scheduled, she keeps busy reading, crocheting and writing a journal. Mrs. T awakens early in the morning and rarely takes a nap. MDS item Awake Mornings, N1a, is checked. MDS item Involved in Activities, N2, is coded 0 (most of time). Both of these MDS items are required to trigger the Activities RAP; these factors in combination suggest that the focus of the assessment should be on reviewing the current activities plan.

Mrs. C is limited in bed mobility (MDS Item G1aA), with a physical restraint used during part of the day. The presence of any of these items is sufficient to trigger the Pressure Ulcer RAP, focusing on issues of problem avoidance in the future. (Note: other RAPs triggered include ADLs and Physical Restraints.)

Different types of triggers can change the focus of the RAP review. There are four types of triggers:

1. **Potential Problems -** Those factors that suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention. These are usually "narrowly" defined as factors that warrant additional assessment. They include clinical factors commonly seen as indicative of possible underlying problems and consequently have generally been well understood by facility staff members. Examples include the presence of a pressure ulcer or use of a trunk restraint, both of which indicate the need for further review to determine what type of intervention is appropriate or whether underlying behavioral symptoms can be minimized or eliminated by treatment of the underlying cause (e.g., agitated depression).

2. **Broad Screening Triggers** - These are factors that assist staff to identify hard to diagnose problems. Because some problems are often difficult to assess in the elderly nursing facility population, certain triggers have been "broadly" defined and consequently may have a fair number of "false positives" (i.e., the resident may trigger a RAP which is not automatically representative of a problem for the resident). Examples include factors related to delirium or dehydration. At the same time, experience has shown that many residents who have these problems were not identified prior to having triggered for review. Thus careful consideration of these triggered conditions is warranted.

3. **Prevention of Problems** - Those factors that assist staff to identify residents at risk of developing particular problems. Examples include risk factors for falling or developing a pressure ulcer and contractures.

4. **Rehabilitation Potential** - Those factors that are aimed at identifying candidates with rehabilitation potential. Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths. In general, these factors suggest consideration of programs to improve a resident's functioning or minimize decline. For example, MDS item responses indicating "Resident believes he or she is capable of increased independence in at least some ADLs" (G8a) may focus the assessment and care plan on functional areas most important to the resident or on the area with the highest potential for improvement.

Facility staff who are assessing a resident whose condition "triggers" a RAP should know what item responses on the MDS triggered that RAP. This step is often missed, especially if someone other than the person(s) who completed the MDS reviews the trigger legend or the triggering is automated. Referring to the triggers section of the RAP to identify relevant triggers can help to "steer" the assessment to factors particular to the individual resident. For example, if a staff member assigned to assess a resident who has fallen or is at risk for falls knows that the Falls RAP was triggered because the resident had been dizzy during the MDS assessment period (MDS Item J1f - Dizziness was checked), the RAP review would include a focus on causal factors and interventions for dizziness. While reviewing the RAP, other factors may come to light regarding the resident's risk for falls, but knowing the trigger condition clarifies or possibly rules out certain avenues of approach to the resident's problem.

At the same time, there can also be a tendency to believe that the RAP review is limited to only those MDS items that triggered the RAP. Such a view is false and can lead to key causal factors being unnoticed and a less than appropriate plan of care being initiated. Many of the trigger conditions serve to initiate a more comprehensive review process including specific causal factors (as referenced in the Guidelines) that are to be considered relative to the resident's status.

4.5 Assessment of the Resident Whose Condition Triggered RAPs (RAP Process - Step 2)

"Reviewing" a triggered RAP means doing an in-depth assessment of a resident who has a particular clinical condition in terms of the potential need for care plan interventions. The RAP is used to organize or guide the assessment process so that information needed to fully understand the resident's condition is not overlooked.

The triggered RAPs are used to glean information that pertains to the resident's condition. While reviewing the RAP, facility staff considers what MDS items caused the RAP to trigger and what type of trigger it is (i.e., potential problem, broad screen, prevention of problem or rehabilitation potential). This focuses the review on information that will be helpful in deciding if a care plan intervention is necessary, and what type of intervention is appropriate.

The information in the RAP is used to supplement clinical judgment and stimulate creative thinking when attempting to understand or resolve difficult or confusing symptoms and their causes. The Guidelines are an aide, a tool, a starting point. It is the understanding and insight of members of the interdisciplinary team that will help integrate these factors into a meaningful resident assessment and care plan.

4.6 Decision-Making and Documentation of the RAP Findings (RAP Process - Steps 3 and 4)

It is recommended that staff who have participated in the assessment and who have documented information about the resident's status for triggered RAPs be a part of the interdisciplinary team that develops the resident's care plan. The team, including the resident, family or resident representative, makes the final decision to proceed to address the "triggered" condition on the care plan.

In order to provide continuity of care for the resident and good communication to all persons involved in the resident's care, it is important that information from the assessment that led the team to their care planning decision be clearly documented.

It is not necessary to record all of the items referred to in the RAP Guidelines, listing all factors that do and do not apply. Rather, documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident's daily functioning?
- Why did you decide the resident is at risk, or that improvement is possible, or that decline can be minimized?
- How could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

Or, for triggered conditions that do not warrant care planning:

- Why did you determine that the triggered condition is not a problem for the resident?

Written documentation of the RAP findings and decision-making process may appear anywhere in the resident's record. It can be written in discipline specific flowsheets, progress notes, in the care plan summary notes, in a RAP summary narrative, on a RAP questionnaire, etc. Facilities should use a format that provides the information as outlined in SOM #272. If it is not clear that a facility's documentation provides this information, surveyors should ask facility staff to provide such evidence. As stated in 482.20(b)(1)(xvii), "Documentation of participation in assessment: The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed staff members on all shifts."

No matter where the information is recorded, use the "Location and Date of RAP Assessment Documentation" column on the RAP Summary form to note where the RAP review and decision-making documentation can be found in the resident's record. Also indicate in the column "Care Plan Decision" if the triggered problem is addressed in the care plan.

Clarification:

- The RAP documentation requires information from the resident's assessment and staff's decision-making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired caregiver for this resident, will I be able to find and understand the assessment and decision-making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note.

  While interpretations of CMS's requirements have varied, the RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed--RAPs guide further assessment of residents who have or are at risk of developing problems (triggered areas). This assessment is supposed to lend further insight into the problems identified by the MDS. RAP "documentation" involves only what should already be taking place, such as clearly written assessments, decision-making by staff knowledgeable about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.

  What does clear documentation and decision-making mean? Decision-making is a written account of the team's clinical thought processes about the resident assessment findings. To accomplish this process, many people have searched for "user friendly" alternatives to RAP documentation. As a result, an industry of workbooks, flow sheets, checklists and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and made the process more complicated than necessary. Each facility should establish a documentation process that "works" for them and incorporate additional tools only if they are deemed of clear benefit in facilitating documentation and clinical decision-making.

Examples of Resident Assessment Documentation Using RAP Guidelines as a Framework:

The following examples illustrate different ways to document resident status information that the assessor(s) gleaned using RAP Guidelines. This documentation would be referenced by facility staff on the RAP Summary form under the "Location of Information" column, or it could be referenced in a RAP Summary note. Please note that these examples are not related to any particular resident or case example. Also, they are not related to one another. They merely depict samples of written notes.

EXAMPLE #1: This is an example of a note that substantiates the initiation of problem evaluation using RAP Guidelines.

PROBLEM: BEHAVIORAL SYMPTOMS

In the past week Ms. E has resisted physical care, puts up a good struggle with the nurse assistants, hits them and swears at them whenever they try to help her. Prior to admission four weeks ago Ms. E had a stroke that has affected her right side. She also has aphasia. During the first few weeks Ms. E was lethargic and passive. She accepted total care from staff. She was difficult to evaluate in many areas because of her communication difficulties. She has been receiving physical therapy for range of motion exercises without difficulty. These behavioral symptoms with nursing staff are new. When I observed her interactions with staff today it appears that if she is approached from the right she lashes out; from the left she is fine. On a positive note, we are seeing that Ms. E is beginning to have some response to her environment and situation and requires further evaluation regarding a new approach to nursing care, ophthalmology evaluation to rule out visual field deficits, speech therapy referral. We will discuss Ms. E's care at nursing rounds tomorrow and develop a revised plan to address these issues.

EXAMPLE #2: This is an example of 1) documentation in the progress notes of the clinical record clarifying that a problem is present and has been discussed with the resident, and 2) another note that describes the beginning of a work-up to evaluate and treat causes of the problem.

PROBLEM: URINARY INCONTINENCE
Nursing note:

Mrs. D's clothing has been found wet during the night on 3 occasions in the past two weeks. Her nurse assistants have also found that she has been tucking washcloths in her underwear. I spoke with her this morning. She admitted that she has been having some urinary accidents for some time but was hiding them. She cried, saying, "I am so ashamed." I reassured her that although incontinence is not normal, it is common, and should be evaluated for possible treatments. I proceeded to review the type of step-by-step evaluation that could be done, some which could be done here at the facility and, if necessary, she would see some specialists. Mrs. D seemed relieved and asked me to call her daughter with the information. I spoke with Ms. D who agreed with the evaluation. She said that she has been noticing a faint odor of urine when she visits, but her mother always denied any problems. Will contact physician.

G. Hope, RN
8/21/01

EXAMPLE #3: This is an example of a note in a clinical record that could be referenced on the RAP Summary form to substantiate a team's decision to proceed to care planning when a RAP is triggered.

PROBLEM: DELIRIUM
Physician Progress note:

Mr. F has had new symptoms in the past week of altered perceptions (thinks someone keeps jumping through his window at night when the curtain moves), restlessness (pacing) and agitation, and is more confused. A review of his medication sheet shows that his Digoxin dose

was increased from 0.125 mg every other day to 0.25 mg. daily two weeks ago during an episode of congestive heart failure. His appetite has also decreased and he says food is making him sick. He is delusional in his thinking that his food is poisoned. Mr. F's exam is unremarkable for signs of an acute illness or other causes of delirium. His symptoms are consistent with probable Digoxin toxicity. We will obtain a Digoxin level in the morning. In the meantime, I have asked the nursing staff to hold the Digoxin and encourage fluids until we reevaluate in the morning. I will temporarily put him on a low dose of Haldol 0.5 mg twice daily in order to reduce his delusions and distress. I will review his status daily with the goal of tapering him off the Haldol once his mental status returns to baseline.

Ben Todd, M.D.
8/30/01

PROBLEM: DELIRIUM
Nursing note:

Until the acute confusion subsides, Mr. F will receive close observation, monitoring of his intake with encouragement of fluids, cueing during ADLs to help him focus. He will be allowed to pace in the confines of the unit and restricted to the unit until his confusion resolves.

J. Doe, RN
8/30/01

EXAMPLE #4: This case illustrates summary documentation using RAP Guidelines to assess the resident's progress related to a previously noted condition, as well as the success of the care plan over time.

PROBLEM: PRESSURE ULCER OVER RIGHT TROCHANTER

Three months ago, Mr. H developed a Stage III pressure ulcer over his right trochanter when he fell asleep on the spirals of a notebook while reading in bed (pressure). Mr. H had been receiving Ambien 10 mg at bedtime for sleep because he had difficulty falling asleep with a roommate who snores loudly. He was friendly with the roommate and did not want to switch rooms when the opportunity was offered. Deep sleep most likely contributed to his not responding to the spiral by shifting his weight. Mr. H has since agreed to move in with a quieter roommate and discontinue the Ambien. We have been treating the ulcer with surgical debridement as necessary and wet to dry saline dressings three times daily, and the ulcer has cleared up nicely to a dime-size area with clean granulation tissue present. Dr. K discontinued wet to dry dressings and it is being managed with a transparent dressing. Mr. H is back to his usual activities and is adherent to his repositioning program when in bed. We will continue the current care plan.

EXAMPLE #5: This case illustrates documentation, using RAP Guidelines, to assess the progress of a long-stay resident who has chronic Urinary Incontinence AND Pressure Ulcer risk.

PROBLEM: LONG-STANDING URINARY INCONTINENCE AND PRESSURE ULCER RISK

Mr. F is a severely demented gentleman who suffers from immobility secondary to dementia and disuse. He has tight contractures of his elbows, hips, knees, and ankles making toileting difficult. Mr. F is frail, primarily bed- and recliner chair-bound. He is totally dependent on staff for care in ADLs, including eating. He has long-standing incontinence that has been managed for the past year with an external catheter to protect his skin (He has a history of rashes). When transferred, he is always placed on pressure relieving devices. He receives a turning and positioning regimen. This regimen has been working and he is free of rashes and skin breakdown. His family and we are in agreement about continuing the current palliative approach to urinary incontinence and preventive approach to ulcer formation.

EXAMPLE #6: This example illustrates that it is not necessary to use the titles of the RAPs to document resident assessment information using RAP Guidelines. The most important goal of documentation is to describe events in a way that everyone can understand what is happening to the resident.

PROBLEM: SIDE EFFECTS FROM ZYPREXA

Mrs. L has been disimpacted of hard, pasty stool twice during the last 6 days. Bowel elimination records show that she has been having infrequent movements. Staff says that she strains at stool. Mrs. L has a long history of schizophrenia. Her psychosis has been managed with various antipsychotics over the years. Most recently (last 6 weeks) we switched her from Haldol to Zyprexa 10 mg. QD for its sedative effects, as she was agitated, wandering, and delusional. The Zyprexa has calmed her down to the point that she is able to sit in on some unit activities without leaving them. The dose was then reduced, but when symptoms recurred, we went back to 10 mg. QD. Her blood pressure has been stable at 138/86 - 146/90 and she has had no falls. The constipation is most likely related to the Zyprexa. However, as her emotional state is currently stable and she is functioning better, we will maintain the current dose, add Colace 100 mg. bid, assure adequate fluid intake, and consult with dietary for suggestions.

EXAMPLE #7: This is an example of a note that illustrates the assessment of multiple problems that were triggered by the MDS. The rationale for combining the assessment into one note is that the resident's risks, problems, causes, and treatments are all interrelated. On a RAP Summary form the following note could be referenced for several triggered RAPs: Falls, Psychotropic Drug Use, Cognitive Loss, Mood State.

PROBLEM: FALLS

Mrs. T's severely depressed mood has improved with Trazodone and involvement in a twice-weekly expressive therapy group. She has been more attentive to her surroundings and has begun to socialize like her old self. She remains disoriented to time and continues to need many reminders for most tasks (her baseline). She has rejoined her baking group that meets every other day. Her appetite has picked up and she eats most meals that are offered. We are

now concerned about two falling episodes this past week. She usually walks alone but is very slow. On Monday night, she seemed to falter in the dining room, but grabbed onto some chairs to steady herself. On Tuesday, she was walking in the corridor with her daughter, faltered, and then her daughter caught her before she fell. Mrs. T insisted that she felt O.K. She denied feeling dizzy or unsteady and said she just tripped over a chair. Yesterday, she fell to the floor in the dining room while getting up from a chair. She sustained no injuries, but she was posturally hypotensive (See vital sign sheet). She was seen by Dr. R who cut back on her Trazodone dose. We will monitor postural vital signs twice daily, and supervise all transfers and walking, and observe for changes in mood. She has been referred to PT for gait evaluation.

EXAMPLE #8: The following example illustrates how to document a situation when the resident functions at a consistent level over a long period of time. The MDS assessment always triggers the same RAP for the same reason, but the resident has shown neither improvement nor decline in function. Note that a nursing diagnosis is used in the problem title rather than the triggered RAP title of ADL-Functional Rehabilitation Potential.

PROBLEM: IMPAIRED PHYSICAL MOBILITY

Mrs. X has impaired mobility related to Parkinson's disease. She transfers and ambulates with a walker and receives non-weight bearing physical assistance of one person to get in and out of bed and for all walking. Occasionally she "freezes" and her medications have been adjusted with success. Mrs. X requires coaxing from staff to take twice-daily walks as she would prefer to stay in her room. However, she enjoys and has been doing well in tri-weekly strength training and stretching classes on the unit. We will continue current care plan of walking, titrating weights per protocol (see strength training progress form) and individual progress note.

OR, THE NOTE COULD LOOK LIKE THE FOLLOWING:

PROBLEM: IMPAIRED TRANSFER AND AMBULATION

S. "I hate exercising even if it's good for me. It's a good thing I like you."

O. See MDS re: function. Occasionally Mrs. X "freezes" and her Sinemet dose has been adjusted by Dr. B with good results. Mrs. X requires coaxing from staff to take twice-daily walks around the unit. She would prefer to stay in her room. However, she seems to enjoy and has made progress in tri-weekly strength training and stretching classes on the unit.

A. Level of mobility is being maintained by walking and strength training programs.

P. Continue current plan, titrating weights as per strength training protocol (see strength training progress form) and progress.

EXAMPLE #9: This note illustrates a case where the resident's MDS assessment has not changed, and although it keeps triggering the same RAP, staff discover new ways of approaching the problem by using the RAP Guidelines.

PROBLEM: IMPAIRED AMBULATION

Mr. H is 25 lbs. overweight and has severe osteoarthritis of both knees. His MDS walking assessments have not changed. He uses a walker and continues to receive weight-bearing assistance of two persons for all transfers. Once he is standing he walks with one-person, non-weight bearing physical assistance. He has been involved in a tri-weekly strength training and daily walking program. During the last 3 months Mr. H's endurance has improved. He can now walk 20 feet without stopping to rest. He has lost 13 lbs. on a weight reduction program and is motivated to lose more. Plan: refer to PT for aerobic activities; refer to orthopedic surgeon to see if Mr. H. is a candidate for knee replacement surgery.

4.7 Development or Revision of the Care Plan (RAP Process)

Following the decision to address a "triggered" condition on the care plan, key staff or the interdisciplinary team should:

- Review the current care plan if the condition is already addressed and make changes, as needed, to reflect the new assessment; and
- Develop new care plan problems, goals and approaches as needed.
- Staff may choose to combine related "triggered" conditions into a single care plan problem that will address the initial set of causal problems and related outcomes identified in the RAP review.

4.8 RAP Clarifications

Clarifications: ◆ It is not necessary to always review and document RAP findings on subsequent assessments the way you would on the initial assessment. Triggers identify areas warranting further assessment. The RAP guides this assessment. For example, if a resident always triggers the Nutritional Status RAP because 25% of the food is uneaten at most meals, further assessment may reveal a swallowing problem, chewing problem, delirium, activity endurance problem, or a healthy lifetime pattern. If the resident chooses to eat frequent snacks, and still is consuming a nutritionally adequate diet, then there is no reason to complete the RAP in its entirety at each full assessment. Clearly document the initial nutritional assessment including: preferences, information that confirms his/her diet is sufficient, any supporting weights or any lab values that give insight into nutrition. If he/she continues to trigger

this RAP for the same reasons, make a one-line entry referring to the original nutritional assessment and indicate that the resident's status has not changed. **On subsequent assessments, it is always necessary to assess the resident to validate that his or her status has not changed as compared to the original RAP assessment and documentation.**

- Statutory requirements dictate that the RAI be completed within 14 days after admission. As an integral part of the RAI, RAPs must be completed within 14 days, which means that the initial RAP Guideline review must be conducted and documented by the end of that time. However, the RAPs may point out the need for a more extensive evaluation, which cannot be completed entirely within the time period. A good example is the Urinary Incontinence RAP. It is generally difficult to perform a complete work-up in 14 days. Even getting initial tests ordered and scheduled can take several weeks. Rather what is intended by "14 days after admission" is when the initial RAP assessment process and documentation must be completed. Certainly you do not wait several weeks to initiate the assessment and make care planning decisions. These initial plans should be outlined in the care plan along with the plan for further assessment.

- The RN Coordinator for the RAP assessment process (VB1) does not need to be the same RN completing the MDS assessment (R2). The date entered in VB2 on the RAP Summary form is the date the RN oversaw completion of the RAPs, indicated the triggered RAPs and completed the location and date of the RAP assessment documentation section. For Admission assessments, the RAP assessment must be completed no later than 14 days after admission. See Chapter 2 for detailed instructions on the MDS completion schedule.

- The Signature of Person Completing Care Planning Decision (VB3) can be any person(s) who facilitates the care planning decision-making. It is an interdisciplinary process. For Admission assessments, the care plan must be completed no later than 21 days after admission or 7 days after the MDS and RAPs are completed. The care planning information on the RAP Summary form would be completed at that time, with the date entered in VB4 being the day that VB3 is signed.

- On the annual assessment, if a resident triggers the same RAP(s) that triggered on the last comprehensive assessment, it is a good idea to review the RAP again. Also keep in mind that even if the RAP triggers for the same reason (no difference in MDS responses), there may be a new or changed related event identified during RAP review, that might call for a revision to the resident's plan of care. The interdisciplinary team determines when a problem or potential problem needs to be addressed in the care plan.